FOR OHF USE

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0039669

Facility Name: LAKE COOK TERRACE NURSING CENTER

Address: 263 SKOKIE BOULEVARD (Number) NORTHBROOK (City) 60062 (Zip Code)

County: COOK

Telephone Number: (847) 564-0505 **Fax #** (847) 564-3775

IDPA ID Number: 363962479001

Date of Initial License for Current Owners: 09/28/81

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/02 to 12/31/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) See Accountants' Compilation Report Attached (Date)
(Print Name and Title) GARRY S. CHANKIN, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER # 0039669 Report Period Beginning: 01/01/02 Ending: 12/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	90	Skilled (SNF)	90	32,850	1
2		Skilled Pediatric (SNF/PED)			2
3	50	Intermediate (ICF)	50	18,250	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	140	TOTALS	140	51,100	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,152	349	2,672	4,173	8
9	SNF/PED					9
10	ICF	35,461	2,114	795	38,370	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	36,613	2,463	3,467	42,543	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.25%

D. How many bed-hold days during this year were paid by Public Aid?
NONE (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 8/1/93

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 8/1/93 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 10 and days of care provided 2,672

Medicare Intermediary ADMINASTAR FEDERAL, INC

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/02 Fiscal Year: 12/31/02

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTI # 0039669 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	169,337	24,335	14,024	207,696		207,696		207,696			1
2	Food Purchase		188,162		188,162	(22,302)	165,861	(109)	165,752			2
3	Housekeeping	186,175	18,982		205,157		205,157		205,157			3
4	Laundry	75,370	25,397		100,767		100,767		100,767			4
5	Heat and Other Utilities			98,552	98,552		98,552		98,552			5
6	Maintenance	80,737	24,883	60,750	166,370		166,370	(8,603)	157,767			6
7	Other (specify):*											7
8	**TOTAL General Services**	511,619	281,759	173,326	966,704	(22,302)	944,403	(8,712)	935,691			8
	B. Health Care and Programs											
9	Medical Director			3,000	3,000		3,000		3,000			9
10	Nursing and Medical Records	1,429,794	68,059	3,850	1,501,703		1,501,703	(982)	1,500,721			10
10a	Therapy	102,887	1,549		104,436		104,436		104,436			10a
11	Activities	100,127	18,178	1,296	119,601		119,601		119,601			11
12	Social Services	169,202		4,693	173,895		173,895		173,895			12
13	Nurse Aide Training			7,050	7,050		7,050		7,050			13
14	Program Transportation			2,635	2,635		2,635		2,635			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,802,010	87,786	22,524	1,912,320		1,912,320	(982)	1,911,338			16
	C. General Administration											
17	Administrative	91,794		201,993	293,787		293,787	(27,705)	266,082			17
18	Directors Fees											18
19	Professional Services			65,425	65,425	(14,880)	50,545	(1,256)	49,289			19
20	Dues, Fees, Subscriptions & Promotions			65,617	65,617		65,617	(45,223)	20,394			20
21	Clerical & General Office Expenses	77,190	1,684	212,468	291,342		291,342	(119,123)	172,219			21
22	Employee Benefits & Payroll Taxes			475,775	475,775	22,302	498,077	(2,600)	495,477			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,227	5,227		5,227	(1,363)	3,864			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			80,058	80,058		80,058		80,058			26
27	Other (specify):*							3,634	3,634			27
28	**TOTAL General Administration**	168,984	1,684	1,106,563	1,277,231	7,422	1,284,653	(193,637)	1,091,016			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,482,613	371,229	1,302,413	4,156,255	(14,880)	4,141,375	(203,330)	3,938,045			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER #0039669 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			91,025	91,025		91,025	133,435	224,460			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			18,947	18,947		18,947	103,404	122,351			32
33	Real Estate Taxes			124,856	124,856	14,880	139,736		139,736			33
34	Rent-Facility & Grounds			362,100	362,100		362,100	(362,100)				34
35	Rent-Equipment & Vehicles			35,144	35,144		35,144		35,144			35
36	Other (specify):*											36
37	TOTAL Ownership			632,072	632,072	14,880	646,952	(125,261)	521,691			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		112,849	163,422	276,271		276,271		276,271			39
40	Barber and Beauty Shops			580	580		580		580			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			76,650	76,650		76,650		76,650			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		112,849	240,652	353,501		353,501		353,501			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,482,613	484,078	2,175,137	5,141,828		5,141,828	(328,591)	4,813,237			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER # 0039669 Report Period Beginning: 01/01/02 Ending: 12/31/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	66,371	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(109)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(5,199)	20		20
21	Owner or Key-Man Insurance	(2,600)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(118,488)	21		24
25	Fund Raising, Advertising and Promotional	(34,024)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(3,538)	20		28
29	Other-Attach Schedule	(18,144)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (115,731)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(212,860)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (212,860)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (328,591)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS
LAKE COOK TERRACE NURSING CENTER

ID# 0039669
Report Period Beginning: 01/01/02
Ending: 12/31/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	RESIDENT CLOTHING	$ (663)	10	1
2	VENDING INCOME	(600)	21	2
3	VETERANS EXPENSES	(319)	10	3
4	BANK CHARGES	(35)	21	4
5	NON-ALLOWABLE LEGAL	(1,256)	19	5
6	REPLACEMENT TAX - BLDG COMPANY	(2,568)	21	6
7	TRUST FEES - BLDG COMPANY	(275)	21	7
8	ICLTC COPE DUES	(2,436)	20	8
9	NON-ALLOWABLE SEMINAR	(523)	24	9
10	UNDOCUMENTED SEMINAR	(840)	24	10
11	LATE FEE	(26)	20	11
12	CAPITALIZED R&M	(8,603)	6	12
13				13
14				14
15				15
16				16
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96				96
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98				98
99				99
100				100
101	Total	(18,144)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER # 0039669 Report Period Beginning: 01/01/02 Ending: 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(109)											(109)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities													5
6	Maintenance	(8,603)											(8,603)	6
7	Other (specify):*													7
8	**TOTAL General Services**	(8,712)											(8,712)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(982)											(982)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**	(982)											(982)	16
	C. General Administration													
17	Administrative			(40,134)		12,429							(27,705)	17
18	Directors Fees													18
19	Professional Services	(1,256)											(1,256)	19
20	Fees, Subscriptions & Promotions	(45,223)											(45,223)	20
21	Clerical & General Office Expenses	(121,966)	2,843										(119,123)	21
22	Employee Benefits & Payroll Taxes	(2,600)											(2,600)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(1,363)											(1,363)	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice													26
27	Other (specify):*			3,634									3,634	27
28	**TOTAL General Administration**	(172,408)	2,843	(36,500)		12,429							(193,637)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(182,102)	2,843	(36,500)		12,429							(203,330)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER # 0039669 **Report Period Beginning:** 01/01/02 **Ending:** 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	66,371	67,064										133,435	30
31	Amortization of Pre-Op. & Org.													31
32	Interest		103,404										103,404	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds		(362,100)										(362,100)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*													36
37	**TOTAL Ownership**	66,371	(191,632)										(125,261)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**													44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(115,731)	(188,789)	(36,500)		12,429							(328,591)	45

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER # 0039669 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED		SEE ATTACHED		SEE ATTACHED		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENTAL INCOME	$ 362,100	G.A.F. PARTNERSHIP		$	$ (362,100)	1
2	V	32	INTEREST INCOME	3,640				(3,640)	2
3	V	32	INTEREST EXPENSE				107,044	107,044	3
4	V	30	DEPRECIATION				67,064	67,064	4
5	V	21	STATE REPLACEMENT TAX				2,568	2,568	5
6	V	21	TRUST FEE				275	275	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 365,740			$ 176,951	$ * (188,789)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER # 0039669 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	SALARY - STAN ARON	$	PRO HEALTH CARE, INC.	100.00%	$ 86,859	$ 86,859	15
16	V	27	PAYROLL TAXES				3,634	3,634	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V	17	MNGMNT. FEES - GAF, LTD.	75,000				(75,000)	23
24	V	17	MNGMNT. FEES - PRO HEALTH	51,993				(51,993)	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 126,993			$ 90,493	$ * (36,500)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER # 0039669 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	MANAGEMENT FEES	$ 150,000	GAF, LTD.	100.00%	$	$ (150,000)	15
16	V	17	MNGMNT. FEES - FINN CONS.				75,000	75,000	16
17	V	17	MNGMNT. FEES - PRO HEALTH				75,000	75,000	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 150,000			$ 150,000	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER # 0039669 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	SALARY - J. FINN	$	FINN CONSULTING, INC.	100.00%	$ 87,429	$ 87,429	15
16	V	27	PAYROLL TAXES						16
17	V								17
18	V	17	MANAGEMENT FEES	75,000				(75,000)	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 75,000			$ 87,429	$ * 12,429	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER # 0039669 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER # 0039669 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER # 0039669 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER # 0039669 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER # 0039669 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER # 0039669 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number LAKE COOK TERRACE NURSING CENT # 0039669 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	STANTON ARON	OWNER	ADMIN	12.95%	SEE ATTACHED	23	35.38%	Alloc. Pro He	$ 86,859	17-7	1
2	JACK FINN	OWNER	ADMIN	17.26%	SEE ATTACHED	18	51.43%	Alloc. Finn C	82,571	17-7	2
3	NANJEAN PAINTER	OWNER	ADMIN	1.44%	SEE ATTACHED	10	20.00%	DIETARY	6,424	1-3	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 175,854		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER # 0039669 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER # 0039669 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: PRO HEALTH CARE, INC. C/O FR&R
Street Address: 111 PFINGSTEN ROAD
City / State / Zip Code: DEERFIELD, IL 60115
Phone Number: (847)236-1111
Fax Number: (847)236-1155

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	SALARY - STAN ARON	AVG. HRS WORKED	51	4	$ 192,600	$ 192,600	23	$ 86,859	1
2	27	PAYROLL TAXES	AVG. HRS WORKED	51	4	8,057		23	3,634	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 200,657	$ 192,600		$ 90,493	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER # 0039669 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: GAF, LTD. C/O FR&R
Street Address: 111 PFINGSTEN ROAD
City / State / Zip Code: DEERFIELD, IL 60115
Phone Number: ((847)236-1111
Fax Number: ((847)236-1155

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	MNGMNT. FEES - FINN CONS.	DIRECT ALLOC	1	1	75,000			75,000	1
2	17	MNGMNT. FEES - PRO HEALT	DIRECT ALLOC	1	1	75,000			75,000	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 150,000	$		$ 150,000	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER # 0039669 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: FINN CONSULTING INC.
Street Address: 2901 W. COYLE
City / State / Zip Code: CHICAGO, IL 60645
Phone Number: ((773)764-3466
Fax Number: (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	SALARY - J. FINN	AVG. HRS WORKED	35	2	$ 170,000	$ 170,000	18	87,429	1
2	27	PAYROLL TAXES	AVG. HRS WORKED	35	2			18		2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 170,000	$ 170,000		$ 87,429	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER # 0039669 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER # 0039669 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER # 0039669 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER # 0039669 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER # 0039669 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER # 0039669 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number LAKE COOK TERRACE NURSING CENT] # 0039669 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	MANUFACTURERS BANK		X	LINE OF CREDIT	VARIES	07/10/00	1,300,000	546,000			18,947	6
7												7
8												8
9	TOTAL Facility Related						$ 1,300,000	$ 546,000			$ 18,947	9
	B. Non-Facility Related*											
10	See Supplemental Schedule						2,265,836	1,379,776			103,404	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$ 2,265,836	$ 1,379,776			$ 103,404	14
15	TOTALS (line 9+line14)						$ 3,565,836	$ 1,925,776			$ 122,351	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTEI # 0039669 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	DUE TO SHERIDAN	X					$	$ 140,000			$	1
2	ALLOCATED - GAF PTSHP	X		MORTAGAGE	40,401	1993	2,265,836	1,239,776			107,044	2
3	ALLOCATED - GAF PTSHP	X		INTEREST INCOME							(3,640)	3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$ 2,265,836	$ 1,379,776			$ 103,404	21

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER # 0039669 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2001 report.	$	155,300	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	136,656	2
3. Under or (over) accrual (line 2 minus line 1).	$	(18,644)	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)	$	143,500	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	14,880	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	139,736	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1997	136,449	8
1998	139,820	9
1999	143,084	10
2000	147,864	11
2001	136,656	12

2002 ACCRUAL = 2001 TAX x 1.05
136656 x 1.05 = 143500 (rounded)

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME LAKE COOK TERRACE NURSING CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0039669

CONTACT PERSON REGARDING THIS REPORT STEVE LAVENDA

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	04-02-202-040-000	LONG TERM CARE PROPERTY	$ 136,656.33	$ 136,656.33
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 136,656.33	$ 136,656.33

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME LAKE COOK TERRACE NURSING CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0039669

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER # 0039669 Report Period Beginning: 01/01/02 Ending: 12/31/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior BRICK Frame BRICK Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY			$ 200,000	1
2					2
3	TOTALS			$ 200,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER # 0039669 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	140			1993	$ 2,132,500	$ 54,679	35	$ 106,625	$ 51,946	$ 720,400	4
5				1993	25,000		35	1,250	1,250	8,750	5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1994	61,594		20	3,079	3,079	25,386	9
10	Various			1995	220,229		20	11,014	11,014	82,975	10
11	Various			1996	141,678		20	7,085	7,085	47,036	11
12	Various			1997	117,480		20	5,875	5,875	33,441	12
13	Various			1998	61,427		20	3,071	3,071	13,941	13
14								-		-	14
15								-		-	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER # 0039669 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$ -	$	$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		584,042	12,385		26,326	13,941	310,964	68
69	Financial Statement Depreciation			45,010			(45,010)		69
70	TOTAL (lines 4 thru 69)		$ 3,343,950	$ 112,074		$ 164,325	$ 52,251	$ 1,242,893	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER # 0039669 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,343,950	$ 112,074		$ 164,325	$ 52,251	$ 1,242,893	1
2	BATH WALLS & FLOORS	1999	12,886		20	644	644	2,415	2
3	WOOD DOORS	1999	3,891		20	195	195	748	3
4	SINK	1999	1,618		20	81	81	311	4
5	DOORS	1999	718		20	36	36	135	5
6	BOILER	1999	2,985		20	149	149	584	6
7	FAUCET	1999	986		20	49	49	188	7
8	TOILETS	1999	3,156		20	158	158	606	8
9	ROOM REMODELING	1999	2,250		20	113	113	414	9
10	ROOM REMODELING	1999	4,354		20	218	218	781	10
11	ROOM REMODELING	1999	3,480		20	174	174	667	11
12	ROOM REMODELING	1999	2,207		20	110	110	376	12
13	DOORS	1999	446		20	22	22	81	13
14	WALLPAPER & TILING	1999	8,242		20	412	412	1,511	14
15	ELECTRICAL	1999	965		20	48	48	176	15
16	LIGHT FIXTURES	1999	2,476		20	124	124	434	16
17	WALLPAPER	1999	1,126		20	56	56	196	17
18	VANITY	1999	1,466		20	73	73	243	18
19	CORNICES	1999	6,954		20	348	348	1,160	19
20	WALL BATH BARS	1999	519		20	26	26	100	20
21	PANELING	1999	785		20	39	39	130	21
22	BATHROOM HARDWARE	1999	460		20	23	23	75	22
23	WALL TILE	1999	930		20	47	47	188	23
24	CORNICES & PANELING	1999	3,882		20	194	194	776	24
25	ROOM REMODELING	1999	5,137		20	257	257	792	25
26	ARCHITECT	1999	8,000		20	205	205	606	26
27	WALLPAPER & CARPETIN	1999	12,296		20	315	315	932	27
28	ARCHITECT	1999	4,060		20	104	104	308	28
29	LANDSCAPING	1999	1,327		20	102	102	354	29
30	OFFICE EXPANSON	2000	129,746		20	3,327	3,327	8,456	30
31	REDECORATING	2000	26,956		20	691	691	1,756	31
32	PUMP	2000	1,409		20	70	70	134	32
33	W. GLASS	2000	650		20	33	33	63	33
34	TOTAL (lines 1 thru 33)		$ 3,600,313	$ 112,074		$ 172,768	$ 60,694	$ 1,268,589	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER # 0039669 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 3,600,313	$ 112,074		$ 172,768	$ 60,694	$ 1,268,589	1
2	WINDOW	2000	772		20	20	20	51	2
3	THERMOPANE WINDOWS	2000	6,244		20	160	160	407	3
4	EXTERIOR LIGHTING	2000	2,569		20	66	66	173	4
5	DOOR RELEASE BUTTON	2000	728		20	19	19	48	5
6	BOILER	2000	660		20	17	17	43	6
7	PAINTING	2000	1,500		20	38	38	97	7
8	GLASS	2000	4,000		20	103	103	253	8
9	WALLPAPER	2000	846		20	22	22	56	9
10	WALLPAPER	2000	6,640		20	170	170	475	10
11	SOUND SYSTEM	2000	783		20	20	20	54	11
12	CURIO CABINET	2000	2,725		20	70	70	160	12
13	WASH SINK	2000	516		20	13	13	32	13
14	TOILET	2000	2,130		20	55	55	126	14
15	WASHROOM REMODELING	2000	7,800		20	200	200	475	15
16	TILES	2000	5,447		20	140	140	333	16
17	ROOFING	2000	1,190		20	31	31	71	17
18	ELECTRIC	2000	800		20	21	21	46	18
19	WA MONITORS	2000	1,030		20	26	26	66	19
20	LANDSCAPING	2000	1,065		20	91	91	246	20
21	WINDOWS AND DOORS	2000	4,599		20	118	118	300	21
22	REFRIGERATOR	2000	2,288		20	59	59	150	22
23	WA MONITOR	2000	2,117		20	54	54	137	23
24	DECORATING	2000	855		20	22	22	54	24
25	WINDOW TREATMENT	2000	5,068		20	130	130	276	25
26	FIRE ALARM	2000	8,781		20	225	225	478	26
27	HEAT EXCHANGER	2000	1,745		20	45	45	99	27
28	VENTING	2000	1,940		20	50	50	106	28
29	CURB/ROOF	2001	685		20	34	34	57	29
30	WALLPAPER	2001	2,000		20	100	100	192	30
31	HOT WATER HEATER	2001	2,123		20	106	106	203	31
32	WINDOW TREATMENT	2001	151		20	8	8	15	32
33	WALLPAPER	2001	333		20	17	17	33	33
34	TOTAL (lines 1 thru 33)		$ 3,680,443	$ 112,074		$ 175,018	$ 62,944	$ 1,273,901	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER # 0039669 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 3,680,443	$ 112,074		$ 175,018	$ 62,944	$ 1,273,901	1
2	PVC PIPING	2001	4,769		20	238	238	357	2
3	EXHAUST FAN	2001	2,426		20	121	121	182	3
4	GLASS	2001	500		20	25	25	35	4
5	WALLPAPER	2001	1,235		20	62	62	88	5
6	BORDER/WALLPAPER	2001	7,263		20	363	363	514	6
7	CURTAINS	2001	7,518		20	376	376	533	7
8	CABINET/BOARD	2001	6,611		20	331	331	441	8
9	WALLPAPER	2001	3,950		20	198	198	248	9
10	PVC PIPING	2001	3,541		20	177	177	207	10
11	CORNICE W/LINED DRAP	2001	8,401		20	420	420	490	11
12	WALLPAPER	2001	4,000		20	200	200	233	12
13	ROOF/WALL REPAIR	2001	8,300		20	415	415	484	13
14	DRYWALL	2001	9,850		20	493	493	534	14
15	WALLPAPER	2001	3,600		20	180	180	195	15
16	WATER SALENOID	2001	630		20	32	32	35	16
17	HEAT INDUCER	2001	1,696		20	85	85	92	17
18	PLUMBING WORK	2001	1,650		20	83	83	90	18
19	PLUMBING WORK	2001	3,925		20	196	196	212	19
20	PIPE REPAIRS	2001	915		20	46	46	50	20
21	PLUMBING WORK	2001	625		20	31	31	34	21
22	WIRING	2001	1,200		20	60	60	65	22
23	FOUNDATION WORK	2001	2,615		20	131	131	142	23
24	WATER HEATER REPAIRS	2001	849		20	42	42	46	24
25	WALL REPAIRS	2001	1,390		20	70	70	76	25
26	AC REPAIR	2001	2,323		20	116	116	126	26
27	DOORS	2001	900		20	45	45	49	27
28	PUMP REPAIRS	2001	560		20	28	28	30	28
29	EVACUATION SIGNS	2001	583		20	29	29	31	29
30	WG MONITOR	2001	1,020		20	51	51	60	30
31	SURVEILANCE CAMERAS	2001	5,825		20	291	291	340	31
32	ALARM/AUTOMATIC DOOR	2001	812		20	41	41	44	32
33	SIGNS	2002	547		20	27	27	27	33
34	TOTAL (lines 1 thru 33)		$ 3,780,472	$ 112,074		$ 180,021	$ 67,947	$ 1,279,991	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER # 0039669 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 3,780,472	$ 112,074		$ 180,021	$ 67,947	$ 1,279,991	1
2	ISOLATION INTERFACE	2002	772		20	39	39	39	2
3	CENTRAL STATION	2002	510		20	17	17	17	3
4	WATER HEATER	2002	5,469		20	205	205	205	4
5	EXAUST FAN	2002	2,269		20	85	85	85	5
6	AWNING	2002	15,280		20	509	509	509	6
7	FIRE RATE DOOR	2002	513		20	17	17	17	7
8	ELECTRICAL PIPE	2002	1,000		20	29	29	29	8
9	HAND RAIL	2002	713		20	21	21	21	9
10	RODING & BRICK WORK	2002	16,200		20	473	473	473	10
11	CUSTOM NURSES STATION	2002	14,500		20	483	483	483	11
12	MAGNETIC DOOR HOLDERS	2002	1,800		20	60	60	60	12
13	DRYWALL	2002	4,250		20	106	106	106	13
14	FIRE DAMPERS	2002	572		20	21	21	21	14
15	FIRE PROTECTION	2002	3,150		20	66	66	66	15
16	WIRE GLASS	2002	800		20	17	17	17	16
17	WINDOWS	2002	8,800		20	183	183	183	17
18	ELECTRIC CIRCUIT	2002	528		20	9	9	9	18
19	ELECTRIC CIRCUIT	2002	3,500		20	44	44	44	19
20	FIRE PROTECTION	2002	35,910		20	449	449	449	20
21	CUBICAL CURT	2002	1,539		20	38	38	38	21
22	STAINED GLASS	2002	890		20	7	7	7	22
23	ELECTRICAL SIGN	2002	4,371		20	36	36	36	23
24	CERAMIC TILE	2002	600		20	3	3	3	24
25	SIGNS	2002	2,079		20	173	173	173	25
26	SIGNS	2002	2,250		20	225	225	225	26
27	WINDOWS	2002	3,000		20	150	150		27
28	WINDOWS	2002	4,000		20	200	200		28
29	PUMP REPAIRS	2002	692		20	35	35		29
30	ENTRANCE DOOR	2002	750		20	38	38		30
31	BASEMENT LIGHT REPAIR	2002	950		20	48	48		31
32	MIXER AMPLIFIER	2002	721		20	36	36		32
33	WALK IN FREEZER REPAIRS	2002	1,671		20	84	84		33
34	TOTAL (lines 1 thru 33)		$ 3,920,521	$ 112,074		$ 183,925	$ 71,851	$ 1,283,306	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER # 0039669 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 3,920,521	$ 112,074		$ 183,925	$ 71,851	$ 1,283,306	1
2	HEAT REPAIRS	2002	817		20	41	41		2
3	TOWER BASIN REPAIRS	2002	561		20	28	28		3
4	GENERATOR WORK	2002	564		20	28	28		4
5	HEATER REPAIRS	2002	1,877		20	94	94		5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,924,340	$ 112,074		$ 184,116	$ 72,042	$ 1,283,306	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER # 0039669 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 3,924,340	$ 112,074		$ 184,116	$ 72,042	$ 1,283,306	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,924,340	$ 112,074		$ 184,116	$ 72,042	$ 1,283,306	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER # 0039669 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 3,924,340	$ 112,074		$ 184,116	$ 72,042	$ 1,283,306	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,924,340	$ 112,074		$ 184,116	$ 72,042	$ 1,283,306	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER # 0039669 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 3,924,340	$ 112,074		$ 184,116	$ 72,042	$ 1,283,306	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,924,340	$ 112,074		$ 184,116	$ 72,042	$ 1,283,306	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER # 0039669 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 3,924,340	$ 112,074		$ 184,116	$ 72,042	$ 1,283,306	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,924,340	$ 112,074		$ 184,116	$ 72,042	$ 1,283,306	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER # 0039669 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 3,924,340	$ 112,074		$ 184,116	$ 72,042	$ 1,283,306	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,924,340	$ 112,074		$ 184,116	$ 72,042	$ 1,283,306	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER # 0039669 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9				1981	5,694		20			5,694	9
10				1982	17,924		20			17,924	10
11				1983	5,201		20			5,201	11
12				1984	27,884		20			27,884	12
13				1985	77,350	2,232	20	3,870	1,638	65,425	13
14				1986	37,603	1,579	20	1,880	301	34,406	14
15				1987	38,247	1,213	20	1,913	700	7,725	15
16				1988	13,918	441	20	650	209	8,376	16
17				1989	53,326	1,559	20	2,667	1,108	26,659	17
18				1990	39,155	1,244	20	1,958	714	18,630	18
19				1991	101,697	1,552	20	5,085	3,533	40,480	19
20				1992	16,406	307	20	821	514	5,337	20
21				1993	149,637	2,258	20	7,482	5,224	47,223	21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER # 0039669 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
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59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 584,042	$ 12,385		$ 26,326	$ 13,941	$ 310,964	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER # 0039669 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 330,558	$ 34,185	$ 36,841	$ 2,656	10	$ 172,457	71
72	Current Year Purchases	21,843	11,427	2,803	(8,624)	10	2,803	72
73	Fully Depreciated Assets	412,444				10	412,444	73
74								74
75	TOTALS	$ 764,845	$ 45,612	$ 39,644	$ (5,968)		$ 587,704	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		VAN	1997	$ 6,999	$ 403	$ 700	$ 297	5	$ 3,733	76
77										77
78										78
79										79
80	TOTALS			$ 6,999	$ 403	$ 700	$ 297		$ 3,733	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,896,184	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 158,089	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 224,460	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 66,371	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,874,743	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER # 0039669 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM	
IN OTHER FACILITY	
COMMUNITY COLLEGE	X
HOURS PER AIDE	84

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	
IN OTHER FACILITY	X
HOURS PER AIDE	40

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$ 2,185	$ 4,865	$	$ 7,050
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$ 2,185	$ 4,865	$	$ 7,050
10	SUM OF line 9, col. 1 and 2 (e)	$ 7,050			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	9
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	4
2. From other facilities (f)	
TOTAL TRAINED	13

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER # 0039669 Report Period Beginning: 01/01/02 Ending: 12/31/02

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 29,370 Description: SEE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY	2002 GMC JIMMY	$ 525.00	$ 5,775	17
18					18
19					19
20					20
21	TOTAL		$ 525.00	$ 5,775	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			8,269			8,269	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			105,655			105,655	4
5	Physician Care	39 - 03	visits			49,498			49,498	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				89,934		89,934	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental						22,915		22,915	13
14	TOTAL			$		$ 163,422	$ 112,849		$ 276,271	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER # 0039669 Report Period Beginning: 01/01/02 Ending: 12/31/02

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/02 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 32,304	$ 202,438	1
2	Cash-Patient Deposits	37,601	37,601	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,176,669	1,176,669	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	2,000	2,000	5
6	Prepaid Insurance	35,157	35,157	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Supplemental Schedule	87,464	87,464	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,371,195	$ 1,541,329	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		200,000	13
14	Buildings, at Historical Cost		2,132,500	14
15	Leasehold Improvements, at Historical Cost	1,093,091	1,500,667	15
16	Equipment, at Historical Cost	379,746	791,259	16
17	Accumulated Depreciation (book methods)	(463,565)	(1,621,598)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Supplemental Schedule			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,009,272	$ 3,002,828	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,380,467	$ 4,544,157	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 248,555	$ 248,555	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	40,869	40,869	28
29	Short-Term Notes Payable	395,000	395,000	29
30	Accrued Salaries Payable	22,416	22,416	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,660	1,660	31
32	Accrued Real Estate Taxes(Sch.IX-B)	143,500	143,500	32
33	Accrued Interest Payable	4,517	12,504	33
34	Deferred Compensation			34
35	Federal and State Income Taxes		2,542	35
	Other Current Liabilities(specify):			
36	See Supplemental Schedule	2,937	2,937	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 859,454	$ 869,983	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	838,757	291,000	39
40	Mortgage Payable		1,239,776	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Supplemental Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 838,757	$ 1,530,776	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,698,211	$ 2,400,759	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 682,256	$ 2,143,398	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,380,467	$ 4,544,157	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER # 0039669 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 466,562	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 466,562	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	215,694	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 215,694	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 682,256	24	*

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER # 0039669 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,935,902	1
2	Discounts and Allowances for all Levels	(119,650)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,816,252	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	389,179	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 389,179	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	127,613	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	10,818	19
20	Radiology and X-Ray		20
21	Other Medical Services	13,060	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 151,491	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	600	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 600	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,357,522	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	966,704	31
32	Health Care	1,912,320	32
33	General Administration	1,277,231	33
	B. Capital Expense		
34	Ownership	632,072	34
	C. Ancillary Expense		
35	Special Cost Centers	276,851	35
36	Provider Participation Fee	76,650	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,141,828	40
41	**Income before Income Taxes (line 30 minus line 40)****	215,694	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 215,694	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? not complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER # 0039669 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,000	2,080	$ 66,934	$ 32.18	1
2	Assistant Director of Nursing	655	679	17,283	25.45	2
3	Registered Nurses	13,857	14,553	285,692	19.63	3
4	Licensed Practical Nurses	14,893	16,315	372,970	22.86	4
5	Nurse Aides & Orderlies	58,697	61,597	668,196	10.85	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,885	7,685	102,887	13.39	8
9	Activity Director					9
10	Activity Assistants	8,526	9,146	100,127	10.95	10
11	Social Service Workers	11,925	12,891	169,202	13.13	11
12	Dietician					12
13	Food Service Supervisor	1,840	2,080	38,703	18.61	13
14	Head Cook					14
15	Cook Helpers/Assistants	17,473	18,360	130,634	7.12	15
16	Dishwashers					16
17	Maintenance Workers	7,207	7,791	80,737	10.36	17
18	Housekeepers	21,786	23,890	186,175	7.79	18
19	Laundry	10,217	10,838	75,370	6.95	19
20	Administrator	2,000	2,080	91,794	44.13	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,500	3,820	77,190	20.21	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,684	1,804	18,719	10.38	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	183,145	195,609	$ 2,482,613 *	$ 12.69	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	167	$ 14,024	01-03	35
36	Medical Director	100	3,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	MONTHLY	3,850	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	20	1,296	11-03	44
45	Social Service Consultant	98	3,933	12-03	45
46	Other(specify)				46
47	PSYCHO-SOCIAL REHAB	25	760	12-03	47
48					48
49	TOTAL (lines 35 - 48)	410	$ 26,863		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER # 0039669 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
SHELLEY MARTINEZ	ADMINISTRATOR	0	$ 91,794
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 91,794

B. Administrative - Other

Description	Amount
GAF, LTD - MANAGEMENT FEES	$ 150,000
PRO HEALTH - ADMINISTRATIVE FEES	51,993
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 201,993

C. Professional Services

Vendor/Payee	Type	Amount
HEALTH REV	PUBLIC AID CONS.	$ 5,249
FR&R	ACCOUNTING	42,585
KIPP STACKSTEDER	COMPUTER	350
PERSONNEL PLANNERS	UNEMPLOYMENT CONS	1,020
FRANK MONTGOMERY	COLLECTION - ADJ P.5	1,256
CRAIG A BURMAN	LEGAL	14,880
SENIOR LIVING SYSTEMS	COMPUTER	85
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 65,425

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 86,998
Unemployment Compensation Insurance	17,229
FICA Taxes	189,185
Employee Health Insurance	92,031
Employee Meals	22,302
Illinois Municipal Retirement Fund (IMRF)*	
UNION HEALTH AND WELFARE	73,724
EMPLOYEE BENEFITS	9,811
CHRISTMAS EXPENSE	4,197
TOTAL (agree to Schedule V, line 22, col.8)	$ 495,477

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 400
Advertising: Employee Recruitment	6,555
Health Care Worker Background Check (Indicate # of checks performed)	
DUES - ICLTC	6,544
DUES AND SUBSCRIPTIONS	3,322
ADVERTISING	30,792
PUBLIC RELATIONS	3,232
YELLOW PAGE ADVERTISING	3,538
LICENSES AND FEES	3,573
Less: Public Relations Expense	(3,538)
Non-allowable advertising	(30,792)
Yellow page advertising	(3,232)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 20,394

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,864
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,864

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER # 0039669 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER # 0039669 Report Period Beginning: 01/01/02 Ending: 12/31/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **ICLTC - $8,980**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **11,794** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **76,650**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **22,302** Has any meal income been offset against related costs? **NO** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% In 14**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees